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Supporting Families, Nurturing Young Children: Early Head Start Programs in 2006

By Elizabeth Hoffmann and Danielle Ewen

Since 1965, Head Start has provided high quality early education and comprehensive support services to the nation's poorest children, from age 3 through school age. In addition to early learning opportunities, Head Start's comprehensive early childhood development programs provide children and families with access to a range of services such as health screenings, referrals and follow-up support, parenting resources, and social services. Head Start emphasizes the importance of parental involvement and staff works to cultivate parents' abilities as their children's first teachers. Research demonstrates that Head Start has had positive impacts on the lives of children and families.¹

In 1995, Early Head Start was created to provide early care and education and comprehensive services to infants and toddlers (from birth to age 3) and supports to pregnant women and families. In 2002, the U.S. Department of Health and Human Services (HHS) released the results of a long-term study that used ran-

dom assignment to determine the impact of participation in Early Head Start on low-income children and their families. The study found that 2-year-old children with at least one year of Early Head Start performed better on measures of cognitive, language, and socio-emotional development than their peers who did not participate. Children who attended Early Head Start continued to outperform children in the control group at age 3. Parents of Early Head Start children also performed better on measures of the home environment, parenting, and knowledge of child development. These parents were also more likely to participate in job training and education and to be employed, in comparison to families who did not participate in Early Head Start.²

Head Start was reauthorized in December 2007 and the new legislation includes several important changes for Early Head Start. Most importantly, half of all new funds appropriated for the Head Start program will be used for Early Head Start expansion. In addition, the legislation allows Head Start programs currently serving preschool-aged children the flexibility to convert some program capacity to provide Early Head Start services

ABOUT THIS SERIES

This is the ninth brief in a series of CLASP analyses of Head Start Program Information Report data. All are available at <http://childcareandearlyed.clasp.org>. Information on 2006 PIR data for Head Start is also available on the Web site. This brief was made possible by a generous grant from the A.L. Mailman Foundation.

to infants and toddlers, based on an assessment of community needs. All Early Head Start teachers must now have infant-toddler development training, and the Secretary of Health and Human Services will set standards for the training and qualifications of Early Head Start home visitors. Each state is also required to have at least one full-time infant-toddler specialist, and 20 percent of training and technical assistance dollars are allocated to Early Head Start. Other new measures are designed to build on Head Start's success by improving the quality of programs, helping more children access Head Start and Early Head Start, and improving coordination of early childhood services at the state and local level.

This brief provides information on Early Head Start programs, staff, and participants; including young children, pregnant women, and their families.³ It updates a

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CHANGES IN EARLY HEAD START FROM 2004

More Early Head Start children are in informal care outside program hours. In 2006, 23 percent of children were reported as needing full-day, full-year child care and using care arrangements outside of Early Head Start, down from 25 percent in 2004. The majority (57 percent) of children who were in a child care arrangement outside of Early Head Start were in informal child care in 2006, compared to 47 percent in 2004 and 39 percent in 2002.

More Early Head Start children received dental visits. Thirty-eight percent of children received dental exams in 2006, up from 30 percent in 2004. The number of children who had a dental exam as part of a well-baby visit also increased, from 61 percent in 2004 to 69 percent in 2006. However, the number of children who had an ongoing source of dental care declined over this period, from 69 percent in 2004 to 65 percent in 2006.

Pregnant women in Early Head Start accessed more services. In 2006, 91 percent of pregnant women had health insurance by the end of the year, 39 percent received dental examinations, and 36 percent received mental health interventions and follow-up. Pregnant women increased their use of each of these services by 5 percentage points since 2004.

Teacher salaries continued to fail to keep pace with inflation. Salaries for teachers with a Child Development Associate (C.D.A.) credential, Associate's Degree (A.A.), or Bachelor's Degree (B.A.) failed to keep pace with inflation between 2004 and 2006, while salaries for teachers with a graduate degree increased slightly in terms of real dollars between 2004 and 2006.

The number of Early Head Start teachers with degrees increased. In 2006, more than half of teachers (52 percent) had an A.A. or higher. This percent has risen steadily over the past few years: in 2004, 46 percent of teachers had an A.A. or higher, compared to just 36 percent in 2002.

The number of family child care providers with credentials increased. Between 2004 and 2006, the number of family child care providers with a C.D.A. credential or equivalent increased from 36 percent to 45 percent. Of the providers with a C.D.A., 42 percent were enrolled in a degree program in 2006, up from only 29 percent in 2004.

similar brief that CLASP published analyzing data from 2003-2004.⁴ The data in this brief come from the 2005-2006 Program Information Reports (PIR), which each Early Head Start grantee is required to submit to HHS annually. Changes from previous years' PIR data are also highlighted in the sidebar: "Changes in Early Head Start from 2004."

An analysis of the 2005-2006 PIR data, highlighted in the rest of this brief, shows the following key findings:

■ **Early Head Start supports families with working parents; many parents also had limited formal education.** In 2006, 66 percent of Early Head Start families had at least one employed parent and 24 percent had at least one parent in school or job training. Thirty-four percent of parents had not graduated from high school and 40 percent had a high school diploma or the equivalent. Four percent had a B.A. or higher.

■ **Early Head Start serves children and pregnant women from diverse racial and ethnic backgrounds.** In 2006, 30 percent of participants were of Hispanic or Latino origin (regardless of race). Forty-two percent of participants were white, 25 percent were African American, 8 percent were bi-racial or multi-racial, and 6 percent were American Indian or Alaskan Native. The racial category Native Hawaiian or other Pacific Islander accounted for less than 2 percent of participants, as did Asians. Fifteen percent of participants did not specify a race and an additional 2 percent of partici-

pants reported their race as "other." In addition, 25 percent of participants lived in homes where English was not the primary language.

■ **Early Head Start provides a broad range of services to low-income children and their families.** Early Head Start families accessed parent education and health education services more widely (65 percent and 60 percent, respectively) and at higher rates than in 2004. Children received medical, dental, and mental health services. The vast majority of pregnant women in Early Head Start (92 percent) received prenatal and postnatal care while enrolled.

■ **Early Head Start provides services through a variety of program options.** Approximately half of Early Head Start funded slots are in center-based programs and about 41 percent are home-based. Four percent of slots are in combination programs, 3 percent in family child care, and 2 percent in locally designed options. Seven percent of all enrolled children received Early Head Start services through a child care partner that had contracted with a center-based program.

■ **Early Head Start promotes better health for young children.** Among children without health insurance at entry into Early Head Start, 54 percent obtained insurance during the program year. In 2006, 93 percent of children in the program had received all immunizations appropriate for their age (or all immunizations possible at the time) by the end of the program year—higher than nation-

al averages. According to the Centers for Disease Control and Prevention, 80 percent of all young children nationwide (ages 19-35 months) had received their recommended vaccination series in 2006. Among young children living in poverty, only 76 percent had received their recommended immunizations.⁵

Early Head Start Programs

All Head Start programs are required to comply with federal Head Start Program Performance Standards. In 1996, these standards were revised to address the needs of infants, toddlers, and pregnant women served by Early Head Start. Head Start Program Performance Standards are designed to promote a nurturing environment that fosters healthy socio-emotional, physical, and cognitive development for children. Central to this goal is a secure relationship between teachers or home visitors and infants and toddlers,⁶ created by providing consistent, long-term care that is sensitive to the child's family, culture, and language.⁷

According to the PIR, funded enrollment in Early Head Start in 2006 was 62,023, of which 60,726 slots were funded by the Administration for Children and Families (ACF) within HHS. Funding for 1,297 slots came from other sources, including other federal or state funding and private resources such as general state revenues (see sidebar), Child Care and Development Block Grant funds, Temporary Assistance for Needy Families (TANF) funds, and support from foundations.

Head Start Regulations require each program to conduct a community needs assessment and design Early Head Start programs accordingly.⁸ Early Head Start services may be administered through several program options, including: center-based programs, home-based services consisting of home visits and group socialization activities, combination programs that include center- and home-based services, and locally designed programs created by the grantee and approved by the federal government.⁹ In 2000, the Office of Head Start (then the Head Start Bureau) proposed adding family child care as a formal program option after successful demonstration projects. The proposed rules for family child care¹⁰ were never formally finalized and adopted. However, other guidance from the Office of Head Start discusses considerations for Early Head Start grantees contracting with child care partners and family child care homes to deliver Early Head Start programs that meet Program Performance Standards,¹¹ and encourages flexibility in program options to meet families' needs.¹²

In 2006, just over half of Early Head Start slots (51 percent) were in center-based programs (see Figure 1). Most center-based programs (91 percent) were full-day (as defined by Head Start)—operating at least six hours per day—and five days per week; 4 percent were part-day, five-day-per-week programs. Just 5 percent of center-based slots were in four-day programs operating either full- or part-day. Seven percent of all children who enrolled were reported to receive Early Head Start services through a child care partner that had con-

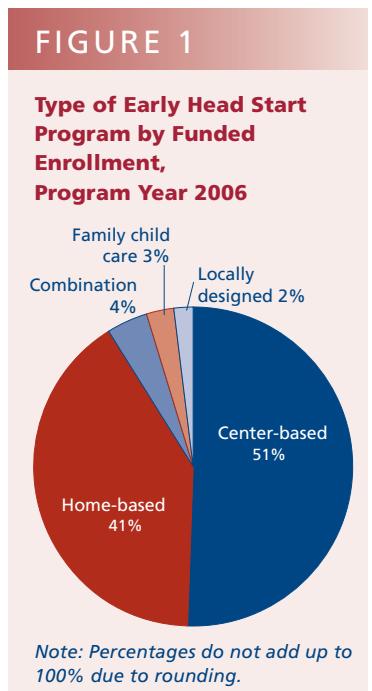
STATE INITIATIVES TO EXPAND ACCESS TO EARLY HEAD START

A forthcoming paper by CLASP and ZERO TO THREE reviews initiatives underway in 19 states to expand the Early Head Start program model.¹³ States are using the following four models, with some states reporting multiple approaches:

- **Extend the day or year of existing Early Head Start services.** The most common approach is to help extend the day or year of Early Head Start services by making additional funding available (often from the child care subsidy system) or through policies to ease the process of blending funding.
- **Expand the capacity of existing Early Head Start and Head Start programs to increase the number of children and pregnant women served.** Some states expand the capacity of existing federal Early Head Start grantees to serve more infants and toddlers (or to federal Head Start grantees to begin serving younger children), by providing grants or by allowing existing state supplemental funding for Head Start programs to include Early Head Start slots.
- **Provide resources and assistance to child care providers to help them deliver services meeting Early Head Start standards.** A few initiatives leverage new funds and supports to help child care providers implement most Early Head Start standards.
- **Support partnerships between Early Head Start and center-based and family child care providers to improve the quality of care.** Some states fund partnerships for Early Head Start programs to deliver services in child care settings or family child care homes.

tracted with a center-based Early Head Start program.

An additional 41 percent of slots were home-based programs. Four percent of slots were combination programs of center-based and home-based services, and 2 percent were locally designed programs. Family child care slots comprised about 3 percent of



funded Early Head Start slots for children, and 12 percent of all Early Head Start grantees reported providing Early Head Start services in family child care homes to some or all of the children that they were funded to serve.

Early Head Start Children and Pregnant Women

In 2006, Early Head Start served a diverse group of primarily low-income children and pregnant women. Over the course of the program year, 85,531 children and 10,825 pregnant women received Early Head Start services, accounting for about 9 percent of the total Head Start enrollment.¹⁴

The age breakdown of children served in 2006 remained largely unchanged from previous years: 29 percent of children were under age 1, 30 percent were age 1, 33 percent were age 2, and 7 percent were age 3.¹⁵ Similar to

rates in 2004 and 2005, 30 percent of children were enrolled in Early Head Start for their second year, and 11 percent had been enrolled for three or more years in 2006.

Most children and pregnant women (74 percent) qualified for Early Head Start because their families had incomes below the federal poverty level. In 2006, the federal poverty level for a family of four was \$20,000.¹⁶ An additional 20 percent qualified based on participation in public assistance programs. Two percent of children were eligible due to status as a foster child. Only 4 percent of participants were from families earning above the poverty level.

Early Head Start continued to serve an ethnically and racially diverse population. In 2006, 30 percent of participants were of Hispanic or Latino origin (regardless of race).¹⁷ Forty-two percent of participants were white, 25 percent were African American, 8 percent were bi-racial or multi-racial, and 6 percent were American Indian or Alaskan Native. The racial category Native Hawaiian or other Pacific Islander accounted for less than 2 percent of participants, as did Asians. Fifteen percent of participants did not specify a race and an additional 2 percent of participants reported their race as “other.” Twenty-five percent of participants lived in homes where English was not the primary language. Spanish was the most common primary language after English, accounting for 20 percent of all participants, with no other language accounting for more than one percent of participants. Early Head Start programs in California had the largest pro-

portion of participants from homes where English was not the primary language (50 percent), followed by Massachusetts (46 percent). Participants from homes primarily speaking languages other than English accounted for more than one-fourth of Early Head Start participants in 18 states.¹⁸

Head Start Program Performance Standards require that all children receive a medical screening within 45 days of entry and that the staff works with parents to ensure children receive follow-up treatment if necessary.¹⁹ In 2006, 83 percent of children completed a medical screening and among children screened, 20 percent were identified as needing further treatment (see Figure 2). Of these children, 95 percent received the treatment. The most commonly treated conditions included in the PIR were asthma (34 percent) and anemia (17 percent). Over the past five years, these figures on screening and treatment have remained fairly constant (within 4 percentage points).

Head Start Program Performance Standards require programs to determine whether children have access to an ongoing source of medical care (or a “medical home”) within 90 days of program entry. If children are without a continuous source of medical care, Early Head Start staff must work with parents to find a medical home.²⁰ In 2006, 95 percent of children had continuous medical care by the end of the enrollment year. Among children without an ongoing source of medical care at enrollment, 54 percent obtained access to continuous medical care during the program year. This increase is an

percent of children without a medical home at the start of the year obtained a medical home during the program year.

In 2006, 88 percent of children had received all immunizations appropriate for their age or all immunizations possible at the time they enrolled in Early Head Start.²¹ By the end of the program year, 93 percent of children were up to date on immunizations, to the extent possible.

Most Early Head Start children had health insurance or obtained it during the enrollment year. At the end of the Early Head Start year, 95 percent of children had health insurance. Among children without health insurance at the beginning of Early Head Start, 54 percent obtained insurance during the 2006 program year, which was similar to the 2004 rate. Most children (91 percent) with health insurance had coverage through a publicly funded program, includ-

ing: Medicaid (73 percent), State Children's Health Insurance Programs (SCHIP) (7 percent), a combination (9 percent), or another state-funded program (2 percent). Just 8 percent of children with health insurance had private insurance. About 1 percent reported having some other type of insurance.

Early Head Start children's access to an ongoing source of dental care has decreased in recent years, but at the same time, the percent of children receiving preventive dental services has increased. Previously, CLASP reported²² that in 2002 less than half (47 percent) of children had access to continual dental care by the end of the Early Head Start year, a figure which jumped to 69 percent of children in 2004.²³ In 2006, this rate decreased to 65 percent of children (see Figure 3). However, between 2004 and 2006, the number of children who received a professional den-

tal examination in the previous year increased from 30 percent to 38 percent, and dental examinations as part of a well-baby check-up also increased, from 61 percent to 69 percent.

In 2006, 13 percent of Early Head Start children were diagnosed as having a disability. Among these, 56 percent were diagnosed prior to enrolling in Early Head Start and 44 percent were diagnosed during the program year. Ninety-three percent of all children diagnosed with a disability received special education and related services, and 97 percent had an Individualized Education Plan (IEP) or Individual Family Support Plan (IFSP) by the end of the Head Start program year.²⁴

In 2006, pregnant women made up 11 percent of Early Head Start enrollment. One in five pregnant women were under age 18. Research suggests that Early Head Start has positive impacts on teen parents and their children,²⁵ but the PIR child data does not disaggregate by the age of the child's mother. Women enrolled in Early Head Start at varied times during their pregnancy: 30 percent enrolled in Early Head Start during their first trimester of pregnancy, 39 percent enrolled during the second trimester, and 31 percent during the third trimester.

Twenty-two percent of women had pregnancies defined as medically "high-risk."

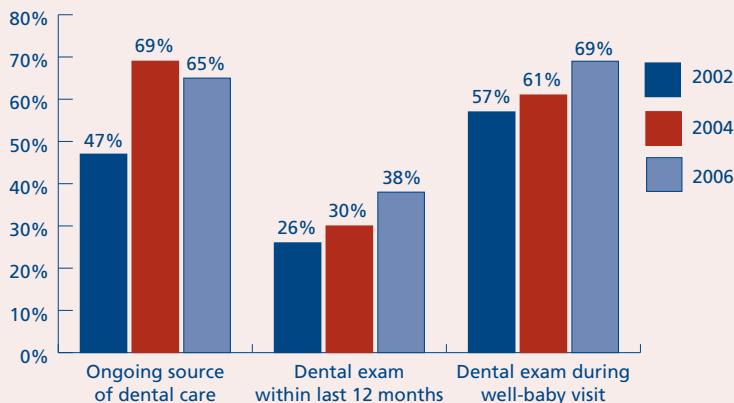
Head Start Program Performance Standards require grantees to provide pregnant women with referrals for prenatal and post-partum care and to provide education and guidance on fetal development, breastfeeding, and

FIGURE 2

Medical Screenings, Treatment, and Services for Early Head Start Children, Program Year 2006

Percentage of Early Head Start children receiving medical screening	83%
Percent diagnosed as needing treatment, of those screened	20%
Early Head Start children receiving follow-up services, of those needing treatment	95%
Among Early Head Start children receiving follow-up services, children received services for the following conditions:	
Asthma	34%
Anemia	17%
Hearing difficulties	13%
Overweight	13%
Vision problems	9%
High lead levels	3%
Diabetes	1%

Note: Percentages do not add up to 100% because other conditions requiring treatment are not reported in the PIR. In addition, children may have received treatment for more than one condition.

FIGURE 3**Measures of Children's Dental Health, Program Years 2002, 2004, and 2006**

related services.²⁶ In 2006, pregnant women accessed a variety of services during and after pregnancy. Ninety-two percent received prenatal and postnatal health care while enrolled in Early Head Start. Additionally, 95 percent of women received prenatal education on fetal development and 94 percent of women received information on the benefits of breastfeeding.

Services to pregnant women improved in 2006 on some key indicators, as compared with previous years. In 2006, 91 percent of pregnant women had health insurance—an increase of 5 percentage points since 2004, when only 86 percent of women were insured (see Figure 4). The number of pregnant women who received a dental examination likewise rose by 5 percentage points over the same period—to 39 percent in 2006. More than one-third of women (36 percent) accessed mental health interventions and follow-up services—a significant increase since 2004,

when 31 percent accessed mental health.

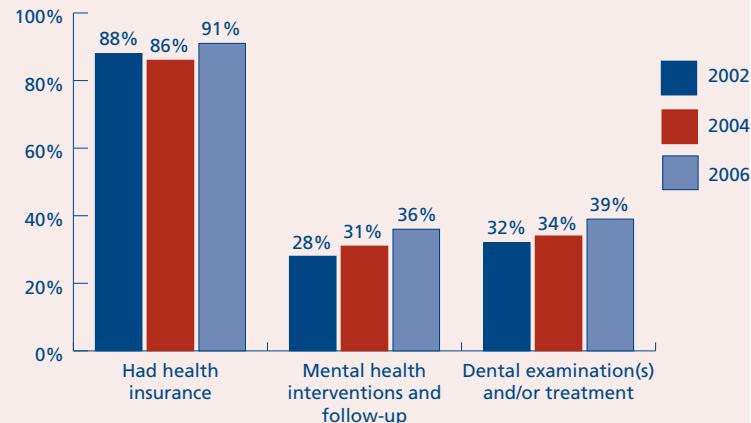
Early Head Start Families

In 2006, 77,431 families participated in Early Head Start. Most Early Head Start families include low-income parents who are working or in school, with limited higher education. In 2006, 42 percent of families included two

parents, and 58 percent of families were headed by a single parent. In two-parent families, 84 percent included at least one employed parent and 20 percent included at least one parent in school or job training. In single-parent families, 53 percent of parents were employed and 26 percent were in school or job training. Two-thirds of all families (66 percent) had at least one employed parent and 24 percent of all families had at least one parent in school or job training.

The majority of parents with children in Early Head Start had not completed formal schooling beyond high school. In 2006, 34 percent of parents had not graduated from high school and 40 percent had a high school diploma or the equivalent. Twenty-one percent had some college, vocational school, or an associate degree. Four percent had a B.A. or higher.

Early Head Start families accessed other social services for themselves and their children.

FIGURE 4**Health Services and Access for Pregnant Women, Program Years 2002, 2004, and 2006**

The number of families participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has increased slightly in recent years, from 70 percent in 2004 to 74 percent in 2006. Participation in other public assistance programs in 2006 remained similar to rates in previous years, with 24 percent of families receiving public assistance through Temporary Assistance to Needy Families (TANF) and 8 percent receiving Supplemental Security Income (SSI).

Some Early Head Start families needed full-day, full-year child care to meet their work and school demands. In 2006, 23 percent of children were reported as needing full-day, full-year child care *and* using care arrangements outside of Early Head Start, down from 25 percent in 2004. More than half (57 percent) of families who used a child care arrangement outside of the Early Head Start program used informal child care from a relative or unrelated adult, either in the child's home or another home (see Figure 5). Formal child care accounted for 41 percent of child care arrangements outside of the Early Head Start program, with 29 percent of families using a center, 12 percent using a family child care home, and 1 percent receiving care through a public school pre-kindergarten program.²⁷

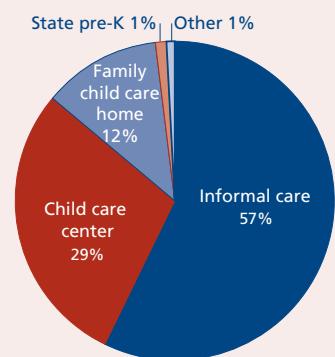
The proportion of families using informal child care has increased steadily since 2002, when only 39 percent of children in care outside of Early Head Start were in informal arrangements (see Figure 6). Conversely, use of child care centers has declined dramatically, from 42 percent in 2002 to 29 percent in 2006.

Head Start Program Performance Standards require that grantees provide parents with opportunities to participate in Head Start activities as volunteers and employees.²⁸ In 2006, current and former Early Head Start parents made up 19 percent of staff and 65 percent of volunteers. The number of parent volunteers increased 5 percentage points since 2004, while the percent of parents as staff has remained fairly constant since 2002. Most programs (86 percent) offered activities specifically geared toward fathers and father figures, and 20 percent of all enrolled children had fathers participating in these activities.

Head Start Program Performance Standards require staff to work with parents to establish mutual trust, identify family strengths, and determine family goals and the services needed to help meet these goals.²⁹ Staff is required to offer parents the

FIGURE 5

Non-Early Head Start Child Care Arrangements for Families Requiring Full-Time Care, Program Year 2006



opportunity to develop a “Family Partnership Agreement” which establishes specific goals and strategies. In 2006, 92 percent of families participated in this partnership process. This percent has

FIGURE 6

Non-Early Head Start Child Care Arrangements for Families Requiring Full-Time Care, Program Years 2002-2006

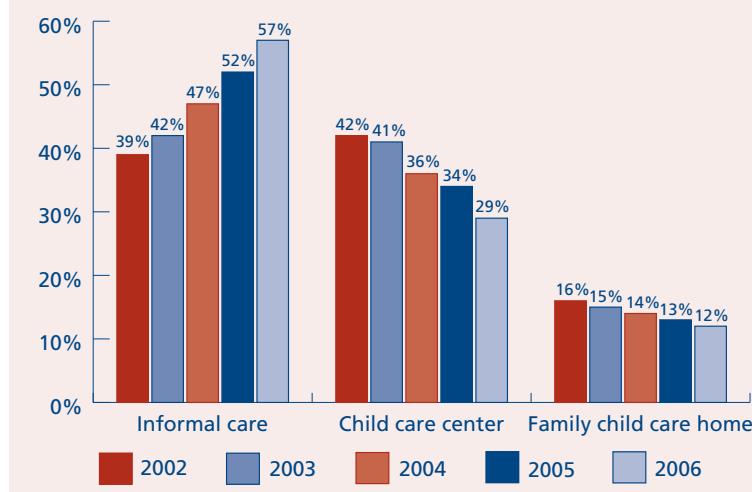
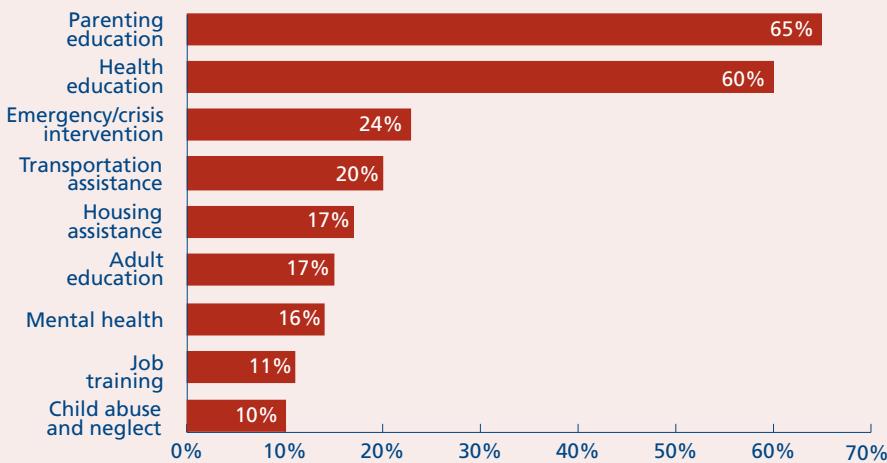


FIGURE 7

Family Services Most Often Accessed by Early Head Start Families, Program Year 2006



increased steadily by about 1 percent per year since 2002, when 87 percent of families developed a Family Partnership Agreement. In 2006, most families (84 percent) accessed one service or more offered by Head Start (see Figure 7). Families increased their use of the two most popular services, parenting education and health education, over the past two years. In 2006, nearly two-thirds of families participated in parenting education (up from 58 percent in 2004), and 60 percent of families accessed health education (up from 55 percent). Families accessed other services at similar rates to 2004, and the order of which services were used most frequently remained the same. These other services included emergency/crisis intervention (24 percent), transportation assistance (20 percent), housing assistance (17 percent), adult education (17 percent), mental health services (16 percent), job training (11 percent), and child abuse and neglect services (10

percent). Early Head Start also offered ESL training, substance abuse prevention and treatment, domestic violence services, child support assistance, assistance to families of incarcerated individuals, and marriage education, all of which were accessed by less than 10 percent of families. Five percent of families served were homeless; of these, 59 percent acquired housing during the enrollment year.

Early Head Start Staff

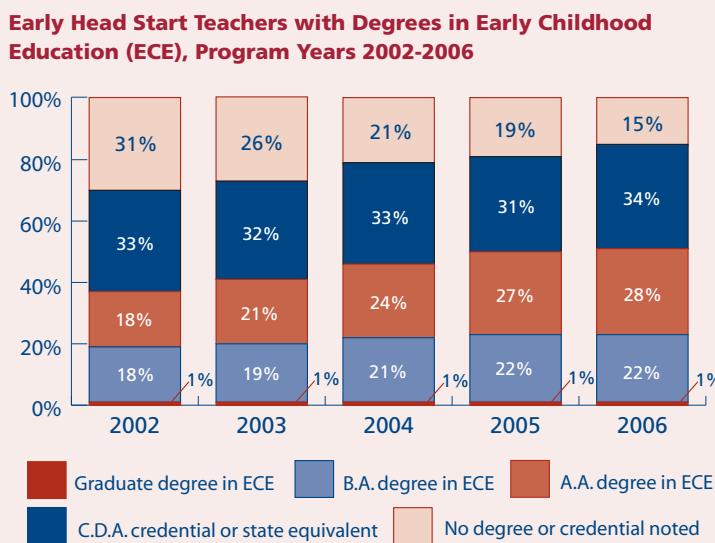
The Head Start Program Performance Standards emphasize the importance of a nurturing, responsive, and consistent caregiver to support healthy development in young children. Each teacher may care for a maximum of four infants or toddlers and group size is restricted to eight children. All program staff included in the adult to child ratio must have at minimum a Child Development Associate (C.D.A.) credential.³⁰

The number of Early Head Start teachers with a degree has increased rapidly in recent years. In 2006, a little more than half (52 percent) of Early Head Start teachers had an A.A. or higher.³¹ In comparison, 46 percent of Early Head Start teachers had an A.A. or higher in 2004, and just 36 percent of teachers had an A.A. or higher in 2002 (see Figure 8). However, the 23 percent of teachers with a B.A. or higher in 2006 was largely unchanged from 2004. Among teachers without a degree in 2006, many had a credential or were pursuing a degree program. Thirty-four percent of teachers had a C.D.A. or state equivalent and of these teachers, 38 percent were in a degree program (down from 46 percent in 2004). Among teachers without a degree or C.D.A., 60 percent were in a degree program or C.D.A. training.

Early Head Start home visitors provided the Early Head Start program to 41 percent of enrolled children through the home-based program option. The qualifications of Early Head Start home visitors improved between 2002 and 2004, but have since remained constant. In 2006, 65 percent of home visitors had an A.A. or higher, and 45 percent had a B.A. or higher. Eighty percent had at least a C.D.A., and of those with a C.D.A., one-quarter were enrolled in a degree program.

Family child care providers served 3 percent of Early Head Start participants in 2006, and have substantially increased their credentials over the past few years. Between 2004 and 2006, the number of family child care providers with a C.D.A. creden-

FIGURE 8



Notes: Percentages may not add up to 100% due to rounding.

Early Head Start teachers are defined as the lead teacher or co-lead teacher in a center-based program.

tial or equivalent increased from 36 percent to 45 percent. Of the providers with a C.D.A., 42 percent were enrolled in a degree program in 2006, up from only 29 percent in 2004.

Salaries for Early Head Start teachers ranged from \$21,274 for teachers with a C.D.A. to \$31,869 for teachers with a graduate degree, with an average for all teachers of \$23,070 (see Figure 9).³² Continuing a trend from 2004, salaries for teachers with a C.D.A., A.A., or B.A. failed to keep pace with inflation between 2004 and 2005, and again from 2005 to 2006. Salaries for teachers with a graduate degree increased slightly in terms of real dollars between 2004 and 2006, with an increase between 2004 and 2005, followed by a smaller decrease from 2005 to 2006.³³ Early Head Start teacher salaries were comparable to Head Start preschool teacher salaries

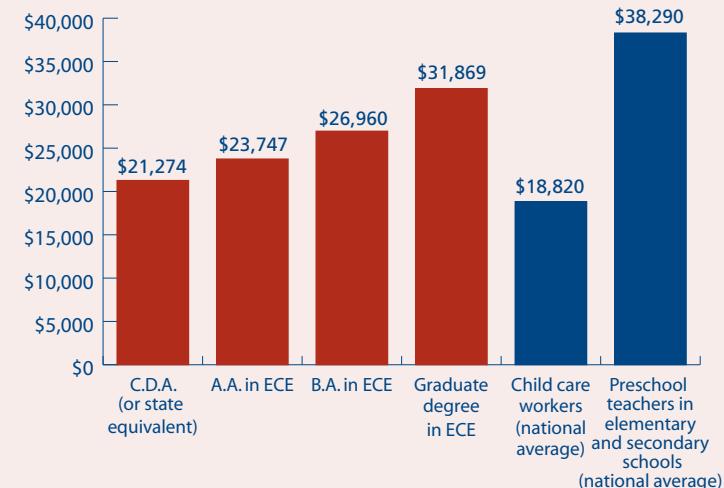
for teachers with a C.D.A. or B.A. On average, Early Head Start teachers with an A.A. earned 5 percent more than Head

Start teachers with an A.A. (\$23,747 compared to \$22,573 respectively). However, Early Head Start teachers with a graduate degree earned 6 percent less than Head Start teachers with a graduate degree (\$31,869 compared to \$33,731 respectively). Early Head Start teacher salaries were higher than the national average for child care workers, which was \$18,820 in 2006.³⁴ However, Early Head Start teachers earned considerably less than preschool teachers in elementary and secondary schools, whose salaries averaged \$38,290 in 2006.³⁵ Early Head Start teacher turnover was 23 percent in 2006 and approximately one-quarter (26 percent) of teachers who left reported leaving to pursue higher compensation and benefits at another job within the same field.

The national average annual salary for Early Head Start home visitors was \$26,788.³⁶ By com-

FIGURE 9

Average Salaries for Early Head Start Teachers by Education Level, Program Year 2006



Note: ECE stands for early childhood education

parison, the national average for child, family, and school social workers in 2006 was \$40,640 annually.³⁷

Early Head Start staff represent diverse racial and ethnic backgrounds. In 2006, 51 percent of child development staff were white, 26 percent were African American, 5 percent were American Indian or Alaska Native, and 2 percent were Asian.³⁸ In addition, 3 percent were bi-racial or multi-racial, and 11 percent did not specify their race. Twenty-four percent of child development staff identified their ethnicity as Hispanic or Latino origin (regardless of race). Twenty-six percent of child development staff were proficient in a language other than English. The PIR does not collect data on staff proficiency in specific languages.³⁹

Conclusion

Younger children are more likely to live in poverty than older children. In 2006, 21 percent of children under age 3 lived below the federal poverty level and 44 percent of children under age 3 were low-income.⁴⁰ Early Head Start provides critical supports to poor infants, toddlers, pregnant women, and their families—supports that may otherwise not be available. As programs begin to implement the new provisions expanding Early Head Start in the 2007 reauthorization, PIR data provide important contextual information about Early Head Start programs and the children and families they serve.

In 2006, Early Head Start served a diverse group of infants, toddlers, and pregnant women, most of whom were from working

families earning below the federal poverty level. Young children, pregnant women, and their families continued to receive comprehensive services through Early Head Start, and the proportion of young children and pregnant women receiving professional dental exams improved. More teachers had degrees in early childhood education, and more family child care providers had credentials in 2006 than in previous years, although salaries did not improve. While these data demonstrate that Early Head Start programs are working hard to meet their promise, very few children—about 3 percent of those eligible—are currently able to participate in these important programs. States and the federal government should support implementation of new opportunities in the 2007 reauthorization to invest in more young children through Early Head Start.

Endnotes

- 1 U.S. Department of Health and Human Services. *Head Start Impact Study: First Year Findings*. June 2005.
- 2 U.S. Department of Health and Human Services. *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*. 2002.
- 3 For information on children, families, staff, and programs in all Head Start programs—including the pre-school Head Start program, Early Head Start, Migrant and Seasonal Head Start, and American Indian and Alaskan Native Head Start—see: Katie Hamm, *Head Start Brief No. 8, More than Meets the Eye: Head Start Programs, Participants, Families, and Staff in 2005*, Center for Law and Social Policy, 2006.
- 4 Katie Hamm and Danielle Ewen, *Head Start Brief No. 7: From the Beginning: Early Head Start Children, Families, Staff, and Programs in 2004*, Center for Law and Social Policy, 2006.
- 5 The Centers for Disease Control and Prevention administers the National Immunization Survey, which examines vaccinations received by children ages 19-35 months. The reported recommended vaccination rates are for the five-vaccine series known as the 4:3:1:3:3 combined series. Rates reported here are for July 2005 – June 2006, to more accurately match the Head Start 2006 program year. Data tables available at: http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0506.htm.
- 6 Jack P. Shonkoff and Deborah A. Phillips, editors, *From Neurons to Neighborhoods: The Science of Early Childhood Development*, 2000, pp. 314-5, and the National Scientific Council on the Developing Child, *Young Children Develop in the Context of Relationships*. 2004. http://www.developingchild.net/pubs/wp/Young_Children_Environment_Relationships.pdf
- 7 National Association for the Education of Young Children, *Responding to Linguistic and Cultural Diversity: Recommendations for Effective Early Childhood Education*, 1995. <http://www.naeyc.org/about/positions/pdf/PSDIV98.PDF>
- 8 Head Start Regulations. 45 CFR 1306.31(b).
- 9 Head Start Regulations. 45 CFR 1306.32 - 45 CFR 1306.35.
- 10 U.S. Department of Health and Human Services, *Proposed Regulation on Family Child Care Homes as a Head Start Program Option*, Log No. ACYF-IM-HS-00-19, September 2000. http://eclkc.ohs.acf.hhs.gov/hslc/Program%20Design%20and%20Management/Head%20Start%20Requirements/IMs/2000/resour_im_00518a_021306.html
- 11 U.S. Department of Health and Human Services, *In What Ways Does the Administration on Children, Youth, and Families (ACYF) Support Early Head Start-Child Care Partnerships?* Early Head Start Tip Sheet 12, 2003. http://www.headstartinfo.org/infolcenter/ehs_tipsheet/tip12.htm
- 12 Judith Jerald and Sarah M. Semlack, *Selecting the Appropriate Program Option*, Head Start Bulletin #69,

2000. http://eclkc.ohs.acf.hhs.gov/hslc/ecdh/ecd/Learning%20Environments/Program%20Options/edudev_art_00209_072505.html

13 Center for Law and Social Policy and ZERO TO THREE, *Building on the Promise: State Initiatives to Expand Access to Early Head Start for Young Children and their Families*, forthcoming.

14 The PIR collects data on all children who participated in the program at any point in the year, including those who do not complete the year; this number is not simply the number of funded slots in the program.

15 In determining a child's age, the 2006 PIR manual instructs Head Start and Early Head Start grantees to "use the same date guideline your local school system uses for determining public school eligibility." For example, if the local school system requires children to be 5 years old on or before September 1 to be eligible for kindergarten, a child participating in Early Head Start who was 2 years old on September 1 should be reported as age 2 in the PIR. Since many children have birthdays during the Early Head Start program year, the exact age breakdown at any given time may vary somewhat.

16 U.S. Department of Health and Human Services, *The 2006 HHS Poverty Guidelines*, <http://aspe.hhs.gov/poverty/06poverty.shtml>.

17 In 2005, the PIR began asking separate questions on race and ethnicity, to reflect that "Hispanic" is an ethnicity rather than a race.

18 The 18 states are AZ, CA, CO, CT, DC, DE, IL, MA, MD, NE, NJ, NM, NV, NY, OR, UT, VA, and WA.

19 Head Start Program Performance Standards. 45 CFR 1304.20(b)(c). The PIR includes all children who were enrolled in Head Start at any point during the program year, including those who dropped out of Head Start before 45 days of enrollment, the time frame during which Head Start programs are required to provide medical and dental screenings.

20 Head Start Program Performance Standards. 45 CFR 1304.20(a)(1)(i)(ii).

21 Children in the category "all immunizations possible" are not on the schedule recommended for their age group but have been brought up to date to the maximum extent possible, given the late start on their immunization schedule.

22 Hamm and Ewen, *Head Start Brief No. 7*.

23 In May 2003, the American Academy of Pediatrics released a policy statement in *Pediatrics* Vol. 111, No. 5 entitled "Oral Health Risk Assessment Timing and Establishment of the Dental Home," which encouraged dental care beginning at age 1, particularly for low-income children. This may have contributed to the increase in the number of children with a dental home in 2004.

24 Only children ages 3 and older receive an IEP; infants and toddlers are served through an IFSP.

25 Center for Law and Social Policy, *Early Head Start and Teen Parent Families: Partnerships for Success*, 2007. http://www.clasp.org/publications/ehs_teens.pdf

26 Head Start Program Performance Standards. 45 CFR 1304.40 (c)(1)-(3).

27 Percentages do not add to 41 percent due to rounding. Since the children in each type of child care arrangement are also enrolled in full-day (at least six hours) or part-day Early Head Start programs, the amount of time spent in each child care arrangement may vary. Also, these percentages do not reflect whether a child was in multiple care arrangements besides Early Head Start—only the primary other source of care is included in this question.

28 Head Start Program Performance Standards. 45 CFR 1304.40(d)(3).

29 Head Start Program Performance Standards. 45 CFR 1304.40(a)(1)(2).

30 Head Start Program Performance Standards. 45 CFR 1304.52(f) and 45 CFR 1304.52(g)(4).

31 Early Head Start teachers are defined as the lead teacher or co-lead teacher in a center-based program. Additional staff categories include assistant teachers, home-based visitors, and family child care teachers. These staff members' qualifications are reported separately in the PIR from teacher qualifications.

32 Salary figure calculated by CLASP.

33 Based on CLASP calculations after adjusting for inflation using CPI indicators for fiscal years.

34 U.S. Department of Labor, Bureau of Labor Statistics. *May 2006 National Occupational Employment and Wage Estimates*, 2006. http://www.bls.gov/oes/oes_data.htm Wages are adjusted to reflect year-round, full-time wages for each occupation.

35 Ibid.

36 Salary figure calculated by CLASP. The PIR does not provide salaries for home visitors by education level.

37 U.S. Department of Labor, Bureau of Labor Statistics. *May 2006 National Occupational Employment and Wage Estimates*. Wages are adjusted to reflect year-round, full-time wages for each occupation.

38 Child development staff includes Early Head Start staff who work directly with children, including teachers, teacher assistances, family child care providers, and home visitors.

39 CLASP has recommended improvements to the PIR, including better data collection on the languages spoken by families and language proficiency of staff. See: Hannah Matthews and Deanna Jang, *The Challenges of Change: Learning from the Child Care and Early Education Experiences of Immigrant Families*, 2007.

40 National Center for Children in Poverty, *Basic Facts About Low-Income Children: Birth to Age 3*, 2007. http://www.nccp.org/publications/pdf/download_217.pdf. Low-income children are defined as living below 200 percent of the federal poverty level.

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ABOUT OUR WORK

The Center for Law and Social Policy (CLASP) is a national nonprofit that works to improve the lives of low-income people. CLASP's mission is to improve the economic security, educational and workforce prospects, and family stability of low-income parents, children, and youth and to secure equal justice for all. CLASP's child care and early

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education work is dedicated to promoting policies that support both child development and the needs of low-income working parents. CLASP conducts policy analysis, research, and technical assistance to expand access to and resources for high-quality, comprehensive child care and early education; build effective child care and early education systems, including child care subsidies, Head Start, prekindergarten, and other early education initiatives; and ensure these systems can be responsive to the developmental needs of all children, in particular infants and toddlers and children in immigrant families. CLASP's child care and early education work highlights state-by-state data where available. For more information, see <http://childcareandearlyed.clasp.org>.

CLASP POLICY BRIEF

Head Start Series, No. 9

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